PATIENT INFORMATION

EXAM DATE: / /

LAST NAME _____ FIRST NAME _____ ☐M ☐F BIRTH DATE / /

ADDRESS _____ CITY _____ STATE PROVINCE _____ ZIP POSTAL CODE _____

PREFERRED TELEPHONE NUMBER ( ) _____ HOME WORK CELL (CIRCLE ONE) SECONDARY TELEPHONE NUMBER ( ) _____ HOME WORK CELL (CIRCLE ONE)

WE USE PHONE CALLS TO REMIND PATIENTS OF THEIR APPOINTMENTS. WE WILL USE THE PHONE NUMBER YOU PROVIDE AND THE CALL MAY BE LIVE OR PRERECORDED.

EMPLOYER _____ OCCUPATION _____

REFERRED BY _____ EMAIL ADDRESS _____ SIGNATURE _____

INSURANCE INFORMATION

PLAN NAME _____ GROUP _____

INSURED NAME _____ RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ CHILD (CHECK ONE)

INSURED ID# _____ INSURED DATE OF BIRTH / /

MEDICAL AND OCULAR HISTORY

WHAT IS THE REASON FOR TODAY'S EXAM? _____

ARE YOU PLANNING TO GET NEW GLASSES TODAY? YES ☐ NO ☐

ARE YOU PLANNING TO GET NEW CONTACT LENSES TODAY? YES ☐ NO ☐

AGE OF PRESENT GLASSES _____ AGE OF SUNGLASSES _____ DATE OF LAST EYE EXAM / / FROM DR. _____ PREVIOUS PATIENT? ☐ YES ☐ NO

DO YOU OR ANY OF YOUR BLOOD RELATIVES (I.E. GRANDPARENTS, PARENTS, BROTHER OR SISTER) HAVE ANY OF THESE CONDITIONS?

	SELF	RELATIVE	NONE		SELF	RELATIVE	NONE
DIABETES	☐	☐	☐	GLAUCOMA	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	CATARACTS	☐	☐	☐
THYROID PROBLEMS	☐	☐	☐	RETINAL DISEASE	☐	☐	☐
HEART DISEASE	☐	☐	☐	EYE SURGERY	☐	☐	☐
ASTHMA	☐	☐	☐	EYE INJURY	☐	☐	☐
CANCER	☐	☐	☐	OTHER _____	☐	☐	☐

	YES	NO
DO YOU SEE DOUBLE?	☐	☐
FREQUENT HEADACHES?	☐	☐
ARE YOU PREGNANT?	☐	☐
EYES BEEN DILATED?	☐	☐

YEAR? _____

PRIMARY CARE DR. _____

PLEASE EXPLAIN ANY POSITIVE FINDINGS: _____

ARE YOU TAKING ANY EYEDROPS (PRESCRIPTION OR OVER THE COUNTER)? PLEASE LIST. _____

ARE YOU TAKING ANY OTHER MEDICATIONS (PRESCRIPTION OR OVER THE COUNTER)? PLEASE LIST. _____

DO YOU HAVE ANY ALLERGIES, MEDICATION OR OTHER? IF YES, PLEASE EXPLAIN. _____

PROCEED TO CONSULTATIVE Rx FORM